SAU 23
MEDICATION PERMISSION FORM

Student Name:_____ Grade:_____ Date of Birth:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of Medication:_____

Reason for Medication:_____

Form of medication/treatment: ☐Prescription ☐OTC

☐Tablet/capsule ☐Liquid ☐Inhaler ☐Injection ☐Nebulizer ☐Other_____

Instructions (Schedule and dose to be given at school) _____

_____

Start: ☐Date form received ☐Other, as specified_____

Stop: ☐End of school year ☐Other date/duration_____

☐**For episodic/emergency events only**

Restictions and/or importand side effects: ☐No restrictions

☐Yes. Please describe_____

Physician's Signature_____ **Physician's Name**_____

Date_____ Phone_____ Address_____

◆◆◆For Self-Administration ONLY◆◆◆

Pursuant to RSA 200:42-47 SAU 23 schools permits older students to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY

☐No ☐Supervision required ☐Supervision not required

This student may carry this medication ☐No ☐Yes

Please indicate if you have provided additional information:

☐On the back side of this form ☐As an attachment

Signature of Physician or Authorized Provider_____ Date_____

Student Agreement

I have been instructed in the proper use of my prescription medication and fully understand how and when to use this medication. I will always carry my medication with me and will not allow another student to use my medication under any circumstances. I will notify the school nurse or teacher immediately after using my medication.

Student Signature_____ Date_____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. We the parent agree by signing this statement that we will not hold liable any member of the SAU 23 school staff who is directed by the school nurse or the school administration to assist my child with their medication at school and during any school sponsored events.

Parent Signature_____ Date_____